

Home Health Plan of Care (POC)

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests have to be scanned and data entered before the PA Department receives them, which takes up to 24 hours. To access PA on the Portal, go to www.tmhp.com, click on "Providers," then "Prior Authorization" from the left hand menu. Then click "PA on the Portal" from the left hand menu and enter your TMHP Portal account user name and password. To submit by fax, send to 1-512-514-4212.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information, and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

We Agree

Home Health Plan of Care (POC)

Section A: Client Information			
Client's name:		Date of birth:	
Date last seen by doctor:		Medicaid number:	
Section B: Home Health Agency (HHA) Information			
Name:		Fax number:	Telephone:
Address:			
TPI:	NPI:		Taxonomy:
DME TPI:		Benefit Code:	
Section C: Prescribed Pediatric Extended Care Center (PPECC) Provider Information (If known, Home Health Agency to complete this section if client receives PPECC services)			
Name of PPECC provider:		Fax number:	Telephone:
Address:			
TPI:		NPI:	
PPECC Hours of operation: Open: _____ a.m. Close: _____ p.m. <input type="checkbox"/> Central Time <input type="checkbox"/> Mountain Time			
Section D: Physician Information			
Name:			Telephone:
TPI:	NPI:		License number:
Section E: Plan of Care Information			
Status (check one):	<input type="checkbox"/> New Client	<input type="checkbox"/> Extension	<input type="checkbox"/> Revised Request
Original SOC date:		Revised request effective date:	
Services client receives from other agencies:			
Diagnoses:			
Function Limitations/Permitted Activities/Homebound Status:			
Prescribed medications:			
Diet ordered:			
Mental status:			
Prognosis:			
Rehabilitation potential:			
Safety precautions:			

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Section E: Plan of Care Information (cont.)

Medical necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc.):

SN visits requested:

HHA visits requested:

Supplies:

DME Item No. 1	Own <input type="checkbox"/>	Repair <input type="checkbox"/>	Buy <input type="checkbox"/>	Rent <input type="checkbox"/>	How long is this DME item needed?
DME Item No. 2	Own <input type="checkbox"/>	Repair <input type="checkbox"/>	Buy <input type="checkbox"/>	Rent <input type="checkbox"/>	How long is this DME item needed?
DME Item No. 3	Own <input type="checkbox"/>	Repair <input type="checkbox"/>	Buy <input type="checkbox"/>	Rent <input type="checkbox"/>	How long is this DME item needed?
DME Item No. 4	Own <input type="checkbox"/>	Repair <input type="checkbox"/>	Buy <input type="checkbox"/>	Rent <input type="checkbox"/>	How long is this DME item needed?

RN signature:

Date signed:

I anticipate home care will be required:

From:

To:

Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program. Check if this exception applies.

Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician signature:

Date signed: